MDR Tracking Number: M5-04-0715-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 09-22-03.

The IRO reviewed myofascial release rendered from 06-07-03 through 07-12-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-07-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 97032 dates of service 04-24-03 through 07-12-03 (15 DOS) denied with denial code "N" (not appropriately documented). The requestor submitted information that meets documentation criteria. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $330.00 ($22.00 X 15 DOS).

CPT code 97124 dates of service 04-24-03 through 06-28-03 (14 DOS) denied with denial code "N" (not appropriately documented). The requestor submitted information that meets documentation criteria. Additional reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $105.28 ($28.00 X 14 = $392.00 minus carrier payment of $286.72 ($17.92 X 6 DOS and $22.40 X 8 DOS)).

CPT code 99203 date of service 04-24-03 denied with denial code "N" (not appropriately documented). The requestor submitted information that meets documentation criteria. Additional reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $26.64 ($74.00 minus carrier payment of $47.36).

CPT code 97250 dates of service 04-29-03 through 06-28-03 (12 DOS) denied with denial code "N" (not appropriately documented). The requestor submitted information that meets documentation criteria. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $516.00 ($43.00 X 12 DOS).

CPT code 72100 date of service 04-29-03 denied with denial code "N" (not appropriately documented). The requestor submitted information that did not meet documentation criteria. Reimbursement is not recommended.

CPT code 99213 dates of service 04-29-03 through 06-28-03 (12 DOS). The requestor submitted information that meets documentation criteria. Additional reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $168.96 ($48.00 X 12 = $576.00 minus carrier payment of $407.04 ($38.40 X 5 DOS and $30.72 X 7 DOS)).

CPT code 95851 (2 units) date of service 05-01-03 denied with denial code "N" (not appropriately documented). The requestor submitted information that meets documentation criteria. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $72.00 ($36.00 X 2 units).

CPT code 99214 date of service 05-01-03 denied with denial code "N" (not appropriately documented). The requestor submitted information that meets documentation criteria. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of $71.00.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 04-24-03 through 07-12-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 18th day of November 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

December 17, 2003 Amended Letter 11/08/2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: MDR Tracking #: M5-04-0715-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above

referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained an injury on ___ 2/03 when a chair was kicked out from under her and she fell. She reported pain to her lower, mid, and upper back and neck. The patient saw a chiropractor for treatment and therapy.

Requested Service(s)

Myofascial release for dates of service 06/07/03 through 07/12/03

Decision

It is determined that the myofascial release for dates of service 06/07/03 through 07/12/03 were medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient presented to the chiropractor for evaluation. This was performed along with x-rays and a treatment program was begun utilizing chiropractic care and passive therapy. An initial trial of care was done with each date of service being properly documented. After an initial phase of care, subjective and objective findings had improved and additional care was needed and performed. During this time, myofascial release and massage therapy were done on the same visit. These procedures are common and myofascial release is a more intensive massage therapy with the utilization of trigger point therapy. Based upon the documentation, the higher service of myofascial release was appropriate. Therefore, it is determined that the myofascial release for dates of service from 06/07/03 through 07/12/03 was medically necessary to treat this patient's medical condition.

Sincerely,